IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

JAMES G. HUFFMAN	)	
	)	
Plaintiff,	)	
	)	
v.	)	**CIVIL ACTION NO. 2:06-CV-748-MEF**
	)	**(WO)**
SOUTHERN HEALTH SERVICES, *et al.*,	)	
	)	
Defendants.	)	

AFFIDAVIT OF KENNETH NICHOLS, M.D.

Before me, the undersigned notary public, in and for said County and State, personally appeared **Kenneth Nichols, M.D.**, who, after first being duly sworn by me, deposes and states as follows:

1. My name is Kenneth Nichols, M.D. I am over the age of 19 years and have personal knowledge of the facts contained herein.

2. I obtained my medical degree from UAB in 1982. From 1982 to 1985, I performed an internal medicine internship and residency at Baptist Memorial Hospital in Memphis, Tennessee. From July 1985 to the present, I have been in private practice in internal medicine in Prattville, Alabama. I am licensed by the State of Alabama as a medical doctor and have been so since 1985. Since 1997, I have been the medical director of the Autauga County Jail. Since November 2005, I have been employed by Southern Health Partners, Inc. ("SHP") to be the medical director of the Autauga County Jail.

3. SHP provides medical care to inmates in various jail facilities, including the Autauga County Jail. From November 2005 to the present, health care services have been provided to

inmates by SHP pursuant to a contract between SHP and the Autauga County Commission. Health care in the jail is provided under the direction of a medical team administrator ("MTA") as well as a medical director. During the period complained of by the plaintiff in this action, I was the medical director of the jail, and Jennifer Cook, Donna Cooey, Gail Colburn and Tina Ellis have served as the MTA.

4. When an inmate in the jail requires routine medical care, he or she obtains an inmate sick call slip from the corrections officer on duty in the housing unit and that form is provided to the medical staff for action. Routine sick calls are conducted by the medical staff inside the housing unit.

5. As I understand the plaintiff's complaint, the plaintiff alleges that I and SHP's medical nursing staff were deliberately indifferent to the plaintiff by failing to provide him adequate medication for his heart problems, back pain and anxiety/bipolar disorder, which he claims caused him to suffer a heart attack in late April 2005 and to be rushed to Baptist Medical Center Emergency Room in May 2005.

6. I have reviewed SHP's entire medical chart on the plaintiff. I have also reviewed the plaintiff's January and February 2004 medical records from Baptist Medical Center East in Montgomery, Alabama, attached as Exhibit A, his April 27, 2005 discharge summary from Shelby Baptist Hospital in Alabaster, Alabama, attached as Exhibit B, and records related to the plaintiff's May 30, 2006 emergency room admission, attached at Exhibit C

7. The plaintiff was booked into the Autauga County Jail on September 13, 2005. On September 15, 2005, I saw the plaintiff. In this initial presentation, the plaintiff said he was taking Plavix for his heart, Zocor for high cholesterol and Xanax for anxiety. Plaintiff gave a medical history of two stents and a prior heart attack in January 2004. He also mentioned problems with

anxiety and his back and said that he had undergone surgery for a ruptured spleen in November 2004. I assessed him as having arteriosclerotic cardiovascular disease (ASCVD) and prescribed Plavix 75 mg. daily for his heart, Mevacor for cholesterol, Paxil and Atarax for anxiety and Vasotec for high blood pressure.

8. Upon review of the plaintiff's January and February 2004 records from Baptist Medical Center East (Ex. A), the plaintiff did not suffer a heart attack in January 2004. On January 27, 2004, he was admitted to Baptist Medical Center East with complaints of chest pain, and he was seen by Dr. Finklea, who ruled out heart attack. Based on the history taken by Dr. Finklea, the plaintiff had a stenting of his left arterior descending ("LAD") artery in July 2002. He underwent repeat catheterization in January 2003 for recurrent chest discomfort and the stent was found to be open. On January 29, 2004, the plaintiff underwent catheterization performed by Dr. Finklea, who found the plaintiff's LAD stent to be patent and placed another stent in the circumflex artery. In his discharge instructions, Dr. Finklea prescribed Plavix 75 mg daily for three months, which would have expired at the end of April 2004.

9. On September 29, 2005, I saw the plaintiff in follow-up to his September 15th appointment, and he complained that he did not get his heart medications the prior week. My assessment remained ASCVD and I changed his prescription to include Elavil at night to help him sleep.

10. On October 6, 2005, I saw the plaintiff for complaints of not sleeping. I prescribed Elavil 100 mg. at the hour of sleep.

11. On November 8, 2005, I discontinued the plaintiff's Paxil prescription and started him on Fluoxitine (brand name Prozac) 20 mg. for depression and anxiety.

12. On November 9, 2005, I discontinued the plaintiff's prescription for Plavix and prescribed aspirin 325 mg. by mouth twice a day for his heart. Based upon my medical judgment, Plavix was no longer indicated, because it had been 22 months since the plaintiff's last cardiac event in January 2004. Also, Plavix, at that time, was not on SHP's formulary of approved drugs.

13. In November 2005, the plaintiff was administered the following medications:

- Aspirin for his heart.
- Lovastatin (brand name Mevacor) for cholesterol.
- Atarax for anxiety
- Vasotec for high blood pressure.
- Amitriptyline (brand name Elavil) to help him sleep.
- Paxil for depression and anxiety up through November 29, 2005.
- Fluoxitine (brand name Prozac) on November 30, 2005 for depression/anxiety.

14. In December 2005, the plaintiff was administered the following medications:

- Aspirin for his heart.
- Lovastatin for cholesterol.
- Vasotec for high blood pressure.
- Amitriptyline HCL (brand name Elavil) to help him sleep.
- Fluoxitine (brand name Prozac) for anxiety and depression.
- Hydroxyzine PAM (brand name Vistaril) for anxiety.

15. On December 10, 2005, the plaintiff completed an inmate sick call slip, complaining that Dr. Finklea told him that he needed to take Plavix everyday for life. The plaintiff was seen by Gail Colburn, RN– the MTA during this time period-- on December 16, 2005, and Nurse Colburn educated the plaintiff on the medications he was taking and advised the plaintiff that he could take

Plavix if it was brought from home. As stated before, at this juncture, it was my opinion that Plavix was not indicated, although it would not hurt the plaintiff if he were to take it.

16. On January 3, 2006, Angela Henley, LPN, performed a history and physical on the plaintiff. During his history and physical, the plaintiff identified prior heart problems and stated that he had been treated for anxiety and bipolar disorder.

17. From January 1, 2006 through February 6, 2006, the plaintiff was administered the following medications:

- Aspirin for his heart.
- Lovastatin for cholesterol.
- Enalapril Maleate (brand name Vasotec) for high blood pressure.
- Amitriptyline HCL (brand name Elavil) to help him sleep.
- Fluoxitine (brand name Prozac) for anxiety and depression.
- Hydroxyzine PAM (brand name Vistaril) for anxiety.

18. On February 6, 2006, the plaintiff was discharged from the Autauga County Jail.

19. The plaintiff was again booked into the Autauga County Jail on April 30, 2006. In his complaint, the plaintiff claims that he had a heart attack on April 22, 2006, and was discharged from the hospital on April 27, 2006. Attached as Exhibit A is the discharge summary from Shelby Baptist Medical Center dated April 27, 2006. As set out in the discharge summary, the plaintiff was admitted to the hospital with complaints of chest pain, but he was not diagnosed with a heart attack. Instead, the cardiologist recommended that he undergo a cardiac catheterization, which showed no change from his previous catheterization. There was no determination that the plaintiff suffered any injury or harm from not taking Plavix or any other medication.

20. On May 1, 2006, Nurse Colburn performed a medical screening of the plaintiff, wherein she noted that the plaintiff had bruising on his bilateral groin area from heart catheterization. On May 5, 2006, I entered an order prescribing Tylenol for the plaintiff's complaints of pain related to said bruising.

21. The plaintiff returned to the jail with prescriptions for Plavix, monopril and Zocor. On May 2, 2006, I entered an order continuing the plaintiff on all of the same medications he was on at the time he left the jail in February, substituting lovastatin for Zocor, aspirin for Plavix and Vasotec for monopril. Again, based on the plaintiff's history, it was my medical judgment that the plaintiff did not need Plavix for his heart and could be adequately treated with aspirin.

22. On May 3, 2006, the plaintiff was brought to the medical staff complaining of chest pain. He was seen by Angela Henley, LPN, who noted that the plaintiff attributed his chest pain to soreness related to him trying to catch himself from falling. Nurse Henley took the plaintiff's vital signs and monitored him for a couple of hours without further complaint.

23. On May 10, 2006, the plaintiff completed an inmate sick call slip, complaining of an abscess tooth on his right bottom jaw. On May 12, 2006, the plaintiff was seen by Marlo Oaks, RN. Pursuant to my protocol for such complaints, the plaintiff was ordered Keflex and Percogesic and was added to the dental list. On May 24, 2006, the plaintiff was seen by Dr. Roberson, an Autauga County dentist. Dr. Roberson found that the plaintiff had two infected teeth, and he extracted same.

24. On May 11, 2006, I saw the plaintiff, and he complained of pain in the left groin and testicles related to the placement of his heart catheter. I continued the plaintiff on the same medications, which included Tylenol for pain.

25. On May 17, 2006, the plaintiff completed an inmate sick call slip, where he again complained that he was hurting in his groin area where the surgeons had placed his heart catheter.

On May 19, 2006, the plaintiff was seen by Marlo Oaks, RN in response to this sick call slip, and Nurse Oaks noted that the plaintiff was not in acute distress and added the plaintiff to the list of patients for me to see.

26. On May 25, 2006, I saw the plaintiff for his complaints of soreness in his left groin area. I noted that the plaintiff had a tender epigastrium. My assessment was ASCAD and gastritis, and I prescribed Zantac for the gastritis. I also ordered Tylenol to treat the plaintiff's complaints of pain.

27. In May 2006, the plaintiff was administered the following medication:

- Aspirin for his heart.
- Lovastatin (brand name Mevacor) for cholesterol
- Vasotec for high blood pressure.
- Amitriptyline (brand name Elavil) to help him sleep.
- Fluoxitine (brand name Prozac) for anxiety and depression.
- Hydroxyzine PAM (brand name Vistaril) for anxiety.
- Tylenol for pain.
- Keflex for dental complaints.
- Percogesic for dental complaints.
- Zantac for gastritis.

28. On May 30, 2006, the plaintiff complained to the medical staff of chest pain, and I gave a telephone order to send the plaintiff to the emergency room for evaluation. The plaintiff was sent to Baptist Medical Center in Prattville and was seen by Dr. Joel Sullivan, who noted a normal EKG. The plaintiff's records from this ER visit are attached as Exhibit B. Tina Ellis, LPN, documents this emergency room visit on June 3, 2006, but it actually occurred on May 30, 2006.

Based upon the emergency room records, there was no determination that the plaintiff suffered any injury or harm from not taking Plavix or any other medication. Dr. Sullivan's discharge instructions included a prescription for Plavix, but I substituted aspirin for Plavix based on my medical judgment that the plaintiff was responding well to aspirin and did not need Plavix.

29. On June 28, 2006, the plaintiff completed an inmate sick call slip complaining of severe pain in his back, neck and hip from injuries received from a fall down the stairs.

30. On June 29, 2006, I saw the plaintiff in response to these complaints. I assessed the plaintiff with back pain and prescribed a Medrol dose pack, Motrin and Robaxin to treat these complaints of pain.

31. In June 2006, the plaintiff was administered the following medications:

- Aspirin for his heart.
- Lovastatin for cholesterol.
- Enalapril Maleate (brand nameVasotec) for high blood pressure.
- Amitriptyline (brand name Elavil) to help him sleep.
- Fluoxitine (Prozac) for anxiety and depression.
- Hydroxyzine PAM (brand name Vistaril) for anxiety
- Zantac for gastritis.
- Medrol dose pack for back pain.
- Ibuprofen (Motrin) for back pain.
- Robaxin for back pain.

32. On July 4, 2006, the plaintiff completed an inmate sick call slip, wherein he complained that his left ankle was swollen rising out of his fall down the stairs and requested an x-ray.

33. On July 5, 2006, I ordered that the plaintiff receive an x-ray on his left ankle, which was performed by Dr. Randall Finley. Dr. Finley noted that the plaintiff had no fracture, dislocation or any abnormality with his ankle.

34. In July 2006, the plaintiff was administered the following medications:

- Lovastatin for cholesterol.
- Aspirin for his heart
- Enalapril Maleate (brand name Vasotec) for high blood pressure.
- Amitriptyline (brand name Elavil) to help him sleep.
- Fluoxitine (brand name Prozac) for anxiety and depression.
- Hydroxyzine PAM (brand name Vistaril) for anxiety.
- Zantac for gastritis.
- Medrol dose pack for back pain (up through July 5, 2006).
- Ibuprofen (Motrin) for back pain (up through July 5, 2006).
- Robaxin for back pain (up through July 8, 2006).

35. In August 2006, the plaintiff was administered the following medications:

- Lovastatin for cholesterol.
- Aspirin for his heart.
- Enalapril Maleate (brand name Vasotec) for high blood pressure.
- Amitriptyline (brand name Elavil) to help him sleep.
- Fluoxitine (Prozac) for anxiety and depression.
- Hydroxyzine PAM (brand name Vistaril) for anxiety.
- Zantac for gastritis.

36. On August 29, 2006, the plaintiff completed an inmate sick call slip, wherein he requested that the medical staff drop all of his medications except aspirin, Elavil and Vistaril.

37. On September 2, 2006, the plaintiff completed a refusal of treatment and release of responsibility form, wherein he again stated that he wanted all of his medications stopped except Vistaril, Elavil and aspirin.

38. Consistent with the plaintiff's desires, the plaintiff received aspirin, Vistaril and Elavil in September 2006. On September 21, 2006, I saw the plaintiff for complaints of lower back pain. I noted that he was refusing his medication. I ordered that the plaintiff take ibuprofen and Flexaril, a muscle relaxer, for his back pain and also ordered that the plaintiff resume taking Lovastatin for cholesterol and Vasotec for high blood pressure. Consistent with my orders, the plaintiff resumed taking these medications.

39. On October 9, 2006, the plaintiff completed an inmate sick call slip, wherein he complained of experiencing pain in his left abdomen near his rib cage where he had his spleen removed. He also complained of back pain. On October 10, 2006, the plaintiff was seen by Tina Ellis, LPN, who referenced my prior orders for medication.

40. On October 31, 2006, the plaintiff completed an inmate sick call slip, wherein he complained of pain in his abdomen and requested to see me.

41. On November 3, 2006, I saw the plaintiff for these complaints and assessed him with esophageal reflux. I prescribed Reglan to assist him with this problem.

42. In October 2006, the plaintiff was administered the following medications:

- Lovastatin for cholesterol.
- Aspirin for his heart
- Enalapril Maleate (brand name Vasotec) for high blood pressure.

- Amitriptyline (brand name Elavil) to help him sleep.
- Fluoxitine (brand name Prozac) for anxiety and depression.
- Hydroxyzine PAM (brand name Vistaril) for anxiety.
- Zantac for gastritis.
- Mylanta for acid indigestion

43. Based upon my review of the plaintiff's records, my treatment of the plaintiff and my education, training and experience, it is my medical opinion that the plaintiff received appropriate medications for his heart problems and anxiety. Indeed, the plaintiff regularly was administered aspirin for his heart, Lovastatin for cholesterol and Vasotec for high blood pressure. Moreover, he was regularly administered Vistaril and Prozac to combat his anxiety. When the plaintiff complained of back pain–which was not often--he was administered medication to alleviate same. While incarcerated at the Autauga County jail, the plaintiff has not identified nor has he ever informed me or the medical staff that he was taking Percocet for back pain. The plaintiff was not denied any medication, including Plavix, on the basis of cost or expense. On the contrary, my orders prescribing and discontinuing medication to the plaintiff were based solely on my medical judgment of the plaintiff's condition.

44. All necessary care provided to the plaintiff by me and the SHP medical staff was appropriate, timely and within the standard of care.

45. On no occasion was the plaintiff ever at risk of serious harm, nor was I or the medical staff ever indifferent to any complaint that the plaintiff made.

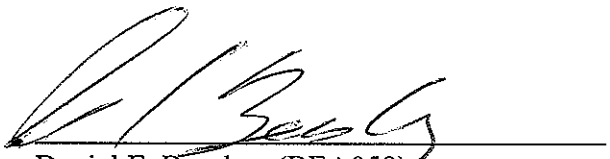
Kenneth Nichols, M.D.

STATE OF ALABAMA)
)
COUNTY OF Autauga)

I, the undersigned Notary Public in and for said county in said state, hereby certify that Kenneth Nichols, M.D. whose name is signed to the foregoing and who is known to me, acknowledged before me that, being fully informed of the contents of said instrument, he executed the same voluntarily on the day the same bears date.

GIVEN UNDER MY HAND and official seal on this the 27 day of November, 2006.

Notary Public
My Commission Expires: 12-3-07



Daniel F. Beasley (BEA059)
Robert N. Bailey, II (BAI045)
Attorneys for Defendants

OF COUNSEL:
LANIER FORD SHAVER & PAYNE P.C.
200 West Side Square, Suite 5000
Huntsville, AL 35801
(256) 535-1100

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which will send notification of such filing to the following:

John Robert Faulk
McDowell, Faulk & McDowell
145 West Main Street
Prattville, AL 36067-3033

and I hereby certify that I have mailed by United States Mail, postage prepaid, the document to the following non-CM/ECF participant:

have mailed by United States Mail, postage prepaid, the document to the following non-CM/ECF participant on this the 27th day of November, 2006.

James G. Huffman
Autauga County Jail
136 North Court Street
Prattville, AL 36067

Of Counsel

Discharge Summary

HUFFMAN, JAMES G - E000092370

Result type:	Discharge Summary
Result date:	May 25, 2004 09:15
Result status:	Unauth
Result title:	DS4
Performed by:	White, Lori on May 25, 2004 09:15
Encounter info:	BAPTIST EAST, Inpatient, 01/27/04 - 01/29/04

D/C summary 1/29/04

DS4

PATIENT VERIFICATION DATA:
HUFFMAN, JAMES H- 0402700752

Transferred to Baptist South care of Dr. Finklea for cardiac catheterization.

CONSULTANTS: Dr. Finklea, Montgomery Cardiovascular Associates.

HOSPITAL COURSE: The patient was admitted with chest pain. He had known cardiac disease with stent placement in the past. He was ruled out for MI. Dr. Finklea was consulted and felt that his chest pain was very suspicious for unstable angina. The patient and Dr. Finklea discussed further care and it was felt that the best course of action was a left heart catheterization. He remained stable during his hospital stay at Baptist East. On 1/29/04 he was transferred to Baptist South under the care of Montgomery Cardiovascular Associates for cardiac catheterization.

LORI WHITE M.D.

LW/ / jcw
D: 05/25/2004
T: 05/26/2004

Completed Action List:
* Perform by White, Lori on May 25, 2004 09:15
* Transcribe by Contributor_system, LANIER on May 26, 2004 22:04

History & Physical

HUFFMAN, JAMES G - E000092370

Result type:	History & Physical
Result date:	January 28, 2004 07:45
Result status:	Unauth
Result title:	HP4
Performed by:	White, Lori on January 28, 2004 07:45
Encounter info:	BAPTIST EAST, Inpatient, 01/27/04 - 01/29/04

pt P 1104

HP4

PATIENT VERIFICATION DATA:
HUFFMAN, JAMES G- 0402700752

CHIEF COMPLAINT: Chest pain.

HISTORY OF PRESENT ILLNESS: The patient is a 50 year old gentleman with CAD, status post stent placement by Dr. Escobar who presented to the Emergency Room with complaints of chest pain. His chest pain started at approximately 4:15, this became very severe and radiated up into his neck and left arm. It felt like an elephant sitting on his chest. He used Nitroglycerin spray and it improved only a little. He was then on his way home in order to rest but his pain became much worse. He became nauseated, vomited, had sweats and shortness of breath. He then presented to the Emergency Room. He was given Nitroglycerin in the Emergency Room and his pain abated.

The patient notes that over the past three weeks he has had great increase in his stress due to loss of his father. He has been having to use his Nitroglycerin 1-2 times per week due to chest pain.

PAST MEDICAL HISTORY: CAD, status post angioplasty and LAD stent placement 100% RCA occlusion with collateral. Repeat cath in 1/03 showed the stent to be open. Hyperlipidemia, peptic ulcer disease, sinus congestion and cough. Anxiety attacks, chronic back pain secondary to herniated disc, peripheral vascular disease.

PAST SURGICAL HISTORY: Back surgery.

MEDICATIONS:
Plavix 75 mg q day
Lipitor 20 mg q day.
Nitrospray prn.
Nexium 40 mg q day
Percocet 10/650 b.i.d.
Xanax 2 mg b.i.d.
Multi-Vitamin
Aspirin 81 mg per day

ALLERGIES: TETRACYCLINE, CODEINE.

FAMILY HISTORY: Unknown, the patient is adopted.

SOCIAL HISTORY: Started smoking again 6 months ago. Tobacco for last 30 years, denies alcohol use.

REVIEW OF SYSTEMS:
GENERAL: The patient has been very stressed over the past several months due to

prolonged illness of his father and then his death.

HEENT: Unremarkable.
LUNGS: Unremarkable.
CARDIOVASCULAR: See HPI.
GI: Has history of peptic ulcer, no current problems.
GU: Admits to problems with intermittent impotence.
EXTREMITIES: Complains of pain in his calves with walking, this stops when he rests. He has had peripheral vascular disease evaluation in the past with Dr. Richardson.

PHYSICAL EXAMINATION:
Thin anxious white male in no distress.

VITAL SIGNS: Temperature 97.6, pulse 52, respirations 20, Blood pressure 110/68.
HEENT: PERRLA, EOMI, Tympanic membranes are clear bilaterally. Mouth clear, throat clear.
NECK: Supple.
LUNGS: Clear to auscultation.
CARDIOVASCULAR: PMI within normal limits, S1-S2 normal. No MRG. Carotids 2+ and equal, no bruit.
ABDOMEN: Soft, non-tender, no hepatosplenomegaly, no mass, no bruit.
EXTREMITIES: No edema, pulses are diminished at + bilaterally.
NEUROLOGIC: Nonfocal.

LABS: Significant for mild anemia with H&H 12.4, 36.3, with normal indices. Chemistries normal except for a CO2 of 33, and total protein mildly low at 6.3. CK 51 and 35 with negative Troponin. EKG normal sinus rhythm, no acute changes. Chest x-ray is negative.

IMPRESSION:
1. Chest pain, probably cardiac in origin. The patient is admitted to rule out MI and he is placed on this protocol. He will receive Nitroglycerin, aspirin, oxygen, and a cardiac consult will be done.
2. Peripheral vascular disease, we discussed the cessation of tobacco and the use of walking. He will be discussing this with his new Primary Care Physician, Dr. Fuentes with who he has an appointment next week.
3. Tobacco use, encouraged to discontinue.
4. Hyperlipidemia on treatment.
5. Chronic back pain, on treatment, he does desire pain management to be in his regimen.

I am sure Dr. Fuentes will be referring him for such.

LORI WHITE, M.D.

B0402900232 HUFFMAN,JAMES G
DOB: 10/29/53 Age:50Y MR #: 319167
Admit Date/Time: 01/29/04 1030A
509 FLEMMING,H FORREST

MONTGOMERY CARDIOVASCULAR ASSOCIATES, P.C.
(334) 280-1500

Hospital Jan. '04

DISCHARGE INSTRUCTIONS

Patient's Name: James Huffman
Referring M.D.: Fuentes
Patient's Phone #:
Hospital: BMC-So
MCA Acct. #: 89226
Discharge Date: 1/30/04
MCA M.D.: Dr. Flemming / Finklea
Follow Up Appointment with Dr. Finklea in 8 weeks
★ Appt. to be mailed

Diagnosis/Reason for Admission:
Angina
CAD s/p PTCA/Stent LAD 7/02
Hyperlipidemia, Tobacco Abuse, PVD s/p (R) fem-pop

Procedures and Treatment: (List significant findings on procedures performed.)
1/29/04 LCORLV
PTCA/Stent to LCX
Cypher

New Allergies:
Discharge Medicines:

1. Plavix 75mg – daily for 3 months
2. Lipitor 20mg – daily
3. Zantac 150mg – daily
4. Xanax & Percocet as directed
5. Nitrostat 0.4 mg – one under tongue every 5 minutes as needed for chest discomfort.
6. Aspirin 81mg – daily
7. Xanax 2mg – one twice a day.

Diet: Low Fat
Physical Activity:
Discharge Instructions:

Authenticated by
H FORREST FLEMMING, MD
On 2/04/04 3:21:15 PM

Return to work: —
May Drive: 1/31

PLEASE BRING THIS SHEET & THE MEDICINES WITH YOU ON YOUR RETURN VISIT TO OUR OFFICE.

PRINTED BY: 2/7/2006 WHITE: Hospital YELLOW: Patient DATE: 9/5/2006 PINK: MCA MCA-CL37 Rev. 9/03

Consult 1/04

BAPTIST MEDICAL CENTER EAST
400 Taylor Road
P.O. Box 17720
Montgomery, Alabama 36193-4201

0402900232

PATIENT: HUFFMAN, JAMES G **ROOM #: 205**
MR #: 000092370 **PATIENT #: 0402700752**
DATE OF CONSULT: 01/28/2004 **ADMIT DATE: 1/27/04**
CONSULTING PHYSICIAN: JOHN L. FINKLEA, M.D.~
ATTENDING PHYSICIAN: LARRY C RIGSBY, MD

___ CONSULT ___CONSULT AND FOLLOW PATIENT WITH ME ___CONSULT AND ASSUME

PATIENT VERIFICATION DATA:
HUFFMAN, JAMES G- 0402700752

DATE OF CONSULTATION: 1/28/04

We appreciate the opportunity of seeing Mr. Huffman in consultation for chest pains. He has been seen by Montgomery Cardiovascular Associates in the past with a history of coronary artery disease, and stenting of his LAD in July of 2002, at that time there was a total occlusion of his right coronary with adequate collateral circulation, left ventricular performance was good and there was no high grade stenosis of the circumflex system. He then underwent repeat catheterization in January 2003 for recurrent chest discomfort and according to his report, the stent was open. Since then he has had chest tightness off and on particularly when he was >>_____<<, he would go long spells without discomfort. He has rather recently lost his father and has been in both financial difficulties as well as having difficulty straightening out his father's affairs. He was under considerable stress yesterday and in fact mad at the time and developed chest tightness, discomfort and some pain. Took Nitroglycerine, it got better. Got in the car and was going home and became diaphoretic, nauseated and came on to the emergency room. Here he has had tightness a good bit of the time, very mild much of the time, but it did seem to increase some when he got up and walked down the hall today. He has actually been outside once to smoke. His cardiac enzymes have been negative and his EKG has been normal. There is a minimal anemia. Mild sinus bradycardia.

He denies orthopnea or paroxysmal nocturnal dyspnea. Denies symptoms of dysrhythmia, currently. Back in January he did have syncope after getting up quickly. His exercise capacity has been reasonably good at about a little over .25 mile and stopped by claudication of his right leg. He has had vascular problems there in the past and nothing done. He denies orthopnea and paroxysmal nocturnal dyspnea. He does have known COPD, bronchitis and tobacco abuse. He stopped smoking with Zyban and nicotine patches and hopes to try again.

PAST SURGICAL HISTORY
1. Lumbar laminectomy
2. Previous stenting of LAD and recath.

PAST MEDICAL HISTORY:
1. Hyperlipidemia
2. Peptic ulcer disease.
3. Lumbar disc disease
4. Peripheral vascular disease
5. History of asthma, bronchitis and perhaps COPD.
6. Chronic anxiety

DRUG ALLERGIES: **CODEINE, TETRACYCLINE**

FAMILY HISTORY: Unknown (adopted).

SOCIAL HISTORY: Smoker, unmarried, does have a girlfriend. No alcohol consumption. No routine exercise.

REPORT OF CONSULTATION

PRINTED BY: b17606 DATE 10/5/2006

PATIENT: HUFFMAN, JAMES G **PATIENT #: 000092370** 0402900232

REVIEW OF SYSTEMS
HEENT: NO sinus difficulties, hear, visual difficulties.
CARDIOVASCULAR/RESPIRATORY: See present illness. No pneumonia.
GI: NO hematemesis or melena. No significant diarrhea or constipation. Does have dyspepsia for which he takes Prevacid 40 and has had some reflux problems.
GU: No dysuria, pyuria, hematuria, stones.
ENDOCRINE: No diabetes mellitus, or thyroid difficulties.

PHYSICAL EXAMINATION: His blood pressure _____.
NECK: His carotids have rapid upstroke without bruits. Central venous pressure is normal.
LUNGS: Clear. No significant murmur, rub or gallop. PMI is normal .
ABDOMEN: Normal, without organomegaly , tenderness, masses, abnormal pulsations, bruit. Femoral pulses are 2+.
EXTREMITIES: Popliteals 2+. 1+ foot pulses. No ankle edema.

EKG is normal. Chest x-ray I will review. EKG normal, mild sinus bradycardia.

PROBLEMS:
1. Coronary artery disease
   1.1. Status post stenting of LAD in January 2003 with known chronically occluded right coronary with good collateral, good left ventricle., stenting in July 2002.
   1.2. Recath January 2003 with patent stent.
   1.3. Recurrent chest discomfort, very worrisome for coronary artery disease.
2. Hyperlipidemia.
3. Continued tobacco abuse.
4. History of asthma and possible COPD.
5. History of dyspepsia and reflux.
6. Syncope in 12/03
7. History of lumbar laminectomy
8. Peripheral vascular disease with claudication right leg.

ASSESSMENT
1. Current symptoms worrisome for unstable angina.

PLAN:
Cardiac catheterization, possible angioplasty. Discussed risks, procedure and rationale with him. He agrees and desires to proceed. He will be transferred over to Baptist Medical Center South.

Authenticated by
H FORREST FLEMMING, MD
On 3/04/04 4:02:49 PM

JOHN L. FINKLEA, M.D.~

JLF/ / pap
D: 01/28/2004
T: 01/29/2004

H16

REPORT OF CONSULTATION

PRINTED BY: b17606 DATE 10/5/2006

CARDIAC##
BAPTIST HEALTH
0509
HUFFMAN, JAMES H
B0402900232
B000319167

NAME OF PROCEDURE: 1. LEFT HEART CATHETERIZATION
2. LEFT VENTRICULOGRAPHY
3. RIGHT AND LEFT CORONARY ARTERIOGRAPHY
4. PTCA AND STENT TO CIRCUMFLEX CORONARY ARTERY

PREOPERATIVE DIAGNOSIS: UNSTABLE ANGINA

POSTOPERATIVE DIAGNOSIS: SUCCESSFUL PTCA AND STENT

I. PROCEDURE: This patient was brought to the Cardiac Catheterization Laboratory, prepped and draped in the usual fashion. 1% Lidocaine was infiltrated into the right groin area. Then, using the Seldinger technique, a 6 French sheath was placed in the right femoral artery and flushed with heparinized saline. A 5 French pigtail catheter was inserted over a guide wire, flushed in the descending aorta, and used to measure pressures in the aorta and left ventricle. This was then used to perform left ventriculography in the biplane projections. This catheter was removed over a guide wire and replaced with Judkins left and right 4 catheters, which were used to perform selective angiography in multiple levels of obliquity. A new 90% stenosis in the large first obtuse marginal branch was noted with no significant restenosis in the stented LAD and continued total occlusion of the right with good collateralization. Plans were made for PTCA of the circumflex coronary artery. A 6 French left 4 catheter was inserted over a guide wire and placed in the ostium of the left coronary artery. A 0.014 Choice wire was manipulated down the circumflex coronary artery and out the obtuse marginal branch, and a 3.5 x 8 mm Cypher stent was positioned and deployed at 13 atmospheres, yielding a final luminal diameter of 3.62 mm. The angiographic result looked excellent. After taking post PTCA views, the procedure was terminated. The sheath was sutured in place. Other apparatus was removed.

Prior to the beginning of the procedure, the patient was given weight-adjusted Heparin, and an ACT measured at greater than 200 seconds. Integrilin bolus was given and infusion begun.

II. HEMODYNAMIC DATA:
A. Aortic pressure: 120/75.
B. Left ventricular pressure: 120/8.

III. LEFT VENTRICULOGRAM: The left ventricle is normal in size with normal contractility in all segments. There is no mitral insufficiency and the aortic structures appeared normal.

IV. CORONARY ARTERIOGRAMS:
A. The left main coronary artery is normal and free of disease. It bifurcates into the LAD and circumflex coronary artery.
B. The left anterior descending coronary artery is large with mild irregularity in the proximal aspect with stenosis up to around 25%. The first diagonal branch is size B to A-B and has mild proximal disease. It is clean distally.

(CONTINUED)

C. The left circumflex coronary artery is large but not dominant. The remaining portion of the circumflex coronary artery is normal. The first obtuse marginal branch is size A. There is a discreet 90% stenosis in its mid portion and is clean distally. The continuation of the circumflex has minimal disease.
D. The right coronary artery is totally occluded after a long area of severe disease in the mid portion. The distal vessel is well collateralized by the left system

V. POST PTCA AND STENT: Residual stenosis in the circumflex coronary artery is 0%. There is no dissection. There is TIMI grade III flow distally.

CONCLUSIONS:
1. NORMAL LEFT VENTRICULAR SIZE AND WALL MOTION.
2. THREE VESSEL CORONARY ARTERY DISEASE AS DESCRIBED ABOVE, INCLUDING NEW LESION IN THE CIRCUMFLEX.
3. NO RESTENOSIS OF LEFT ANTERIOR DESCENDING CORONARY ARTERY.
4. SUCCESSFUL PTCA AND STENT OF CIRCUMFLEX CORONARY ARTERY.

_____
FORREST FLEMMING, M.D.

D: 01/29/2004
T: 02/11/2004
kb

Authenticated by H FORREST FLEMMING, MD On 2/17/04 1:48:51 PM

BAPTIST MEDICAL CENTER
2105 East South Boulevard
Montgomery, Alabama 36111
Telephone 334/288-2100

PATIENT: HUFFMAN, JAMES H **ROOM #: 319**
MR #: 000319167 **PATIENT #: 0402900232**
SURGERY DATE: 01/29/2004 **ADM DT #: 01/29/2004**
SURGEON: FORREST FLEMMING, M.D.
ATTENDING PHYSICIAN: H FORREST FLEMMING, MD

NAME OF PROCEDURE:
1. LEFT HEART CATHETERIZATION
2. LEFT VENTRICULOGRAPHY
3. RIGHT AND LEFT CORONARY ARTERIOGRAPHY
4. PTCA AND STENT TO CIRCUMFLEX CORONARY ARTERY

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POSTOPERATIVE DIAGNOSIS: SUCCESSFUL PTCA AND STENT

I. PROCEDURE: This patient was brought to the Cardiac Catheterization Laboratory, prepped and draped in the usual fashion. 1% Lidocaine was infiltrated into the right groin area. Then, using the Seldinger technique, a 6 French sheath was placed in the right femoral artery and flushed with heparinized saline. A 5 French pigtail catheter was inserted over a guide wire, flushed in the descending aorta, and used to measure pressures in the aorta and left ventricle. This was then used to perform left ventriculography in the biplane projections. This catheter was removed over a guide wire and replaced with Judkins left and right 4 catheters, which were used to perform selective angiography in multiple levels of obliquity. A new 90% stenosis in the large first obtuse marginal branch was noted with no significant restenosis in the stented LAD and continued total occlusion of the right with good collateralization. Plans were made for PTCA of the circumflex coronary artery. A 6 French left 4 catheter was inserted over a guide wire and placed in the ostium of the left coronary artery. A 0.014 Choice wire was manipulated down the circumflex coronary artery and out the obtuse marginal branch, and a 3.5 x 8 mm Cypher stent was positioned and deployed at 13 atmospheres, yielding a final luminal diameter of 3.62 mm. The angiographic result looked excellent. After taking post PTCA views, the procedure was terminated. The sheath was sutured in place. Other apparatus was removed.

Prior to the beginning of the procedure, the patient was given weight-adjusted Heparin, and an ACT measured at greater than 200 seconds. Integrilin bolus was given and infusion begun.

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A. Aortic pressure: 120/75.
B. Left ventricular pressure: 120/8.

III. LEFT VENTRICULOGRAM: The left ventricle is normal in size with normal contractility in all segments. There is no mitral insufficiency and the aortic structures appeared normal.

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B. The left anterior descending coronary artery is large with mild irregularity in the proximal aspect with stenosis up to around 25%. The first diagonal branch is size B to A-B and has mild proximal disease. It is clean distally.
C. The left circumflex coronary artery is large but not dominant. The remaining portion of the circumflex coronary artery is normal. The first obtuse marginal branch is size A. There is a discreet 90% stenosis in its mid portion and is clean distally. The continuation of the circumflex has minimal disease.
D. The right coronary artery is totally occluded after a long area of severe disease in the mid portion. The distal vessel is well collateralized by the left system

PATIENT: HUFFMAN, JAMES H **PATIENT #: 0402900232**

V. POST PTCA AND STENT: Residual stenosis in the circumflex coronary artery is 0%. There is no dissection. There is TIMI grade III flow distally.

CONCLUSIONS:
1. NORMAL LEFT VENTRICULAR SIZE AND WALL MOTION.
2. THREE VESSEL CORONARY ARTERY DISEASE AS DESCRIBED ABOVE, INCLUDING NEW LESION IN THE CIRCUMFLEX.
3. NO RESTENOSIS OF LEFT ANTERIOR DESCENDING CORONARY ARTERY.
4. SUCCESSFUL PTCA AND STENT OF CIRCUMFLEX CORONARY ARTERY.

FORREST FLEMMING, M.D.~

FF/ / kb
D: 01/29/2004
T: 01/29/2004

cc: SHANE CUNNINGHAM, D.O.~

Baptist Medical Center South
2105 E. South Blvd. Montgomery, AL 36116
Fri Jan 30, 2004 09:46 pm

Discharge Cumulative Trend Report from 01/29/04 1115 to 01/30/04 0415

Patient Name: HUFFMAN,JAMES G
Med Rec #: 000319167
Dis Date 01/30/04
Phys-Service: FLEMMING,H FORREST - MEDICINE
Acct #: B0402900232

All Sections-Page 1
Adm: 01/29/04

****

HEMATOLOGY

Last Tech: B6064

Date:	01/30	01/29	Normal Range	
Time:	0415	1115		
New Work:	*	*		
WBC	6.8	6.3	4.0-10.0	(thou/cm
RBC	3.79 L	4.03 L	4.2-5.9	(mill/cu
Hgb	12.1 L	12.9 L	13.0-17.5	(gm/dl)
Hct	35.9 L	37.9 L	39-51	(%)
MCV	95	94	80-100	(fl)
MCH	32	32	26-34	(pg)
MCHC	34	34	31-35	(%)
Plt ct	195	191	150-440	(thou/cm
RDW	13.6	13.5	11.5-14.5	(%)
DIFF				
Neutrophils	63	63	45-75	(%)
Lymphs	25	25	20-53	(%)
Monos	7	7	2-12	(%)
Eos	4	5	0-8	(%)
Basos	1	0	0-2	(%)

COAGULATION

Last Tech: B2225

Date:	01/29	Normal Range	
Time:	1115		
New Work:	*		
Pro Time	11.7	10.5-13.5	(sec)
PTT	32	21-34	(sec)
INR	.96		

Baptist Medical Center South
2105 E. South Blvd. Montgomery, AL 36116
Fri Jan 30, 2004 09:46 pm
Discharge Cumulative Trend Report from 01/29/04 1115 to 01/30/04 0415

Patient Name: HUFFMAN,JAMES G
Med Rec #: 000319167
Dis Date 01/30/04
Phys-Service: FLEMMING,H FORREST - MEDICINE
Acct #: B0402900232

Chemistry Profile-Page 3
Adm: 01/29/04

****

CHEMISTRY PROFILE

Last Tech: B1573

Date:	01/30	01/29				Normal Range	
Time:	0415	1115					
New Work:	*	*					
Calcium	8.8	9.3				8.5-10.5	(mg/dl)
Glucose	83	99				60-120	(mg/dl)
BUN	8	9				7-20	(mg/dl)
Creatinine	0.7	0.9				0.6-1.4	(mg/dl)
Sodium	136	140				135-145	(mmol/L)
Potassium	5.2 H	4.6				3.5-5.0	(mmol/L)
Chloride	101	102				97-112	(mmol/L)
CO2	24	33 H				22-32	(mEq/L)

End of Report

HUFFMAN,JAMES G
000319167
I/P 01/30/04
(M-10/29/53)
Dr. FLEMMING,H FORREST

** DO NOT DISCARD **
Discharge Cumulative Trend Report

PRINTED BY: b17606 DATE 10/5/2006

0402900232 HUFFMAN,JAMES G

Baptist H

I/P AND O/P
ADMISSIONS AND FACESHEET

PC	INIT
11	MP

G

PATIENT NO	DATE	TIME	SEX	COVERAGE	PA	MS	TYPE	BED	STATION/ROOM/BED	MED REC NO
0402900232	01/29/04	1030A	M	10/29/53 50Y	1	D	I/P	CAR	CAR 327/0	319167

PATIENT
NAME & ADDRESS: HUFFMAN,JAMES G
1108 THORNHILL AVE
SELMA AL 36701
SS# 418-78-9424
PH# (334)872-7713
COUNTY DALLAS
EMPLOYER
EMP PH#
OCC EMP STAT EMP I.D. NOT EMPLOYED

GUARANTOR
NAME & ADDRESS: HUFFMAN,JAMES G
1108 THORNHILL AVE
SELMA AL 36701
DOB AGE 10/29/53 50Y
SS# 418-78-9424
PH# (334)872-7713
REL SELF
EMPLOYER
EMP PH#
OCC EMP STAT EMP I.D. NOT EMPLOYED

RELATIVE
NAME & ADDRESS: SHERRILL,DEBBIE J
1108 THORNHILL AVE
SELMA AL 36701
DOB AGE
SS#
PH# (334)872-7713
REL FRIEND
EMPLOYER
EMP PH#
OCC EMP STAT EMP I.D. NOT EMPLOYED

REL 2
NAME & ADDRESS: HUFFMAN,JAMES H
SELMA AL 36701
HM (334)872-7713
PH#
WK

INS #1
INSURANCE CARRIER: BLUE CROSS OF ALABAMA
INSURED NAME: HUFFMAN,JAMES G
REL. TO INSURED: 1
SUBSCRIBER ID#: DIR418789424
GROUP NAME: SPECIAL OPEN ENROLLMENT P
GROUP NUMBER: 91000
GROUP PHONE#: (800)760-6852
APPROVAL#
CONTACT
CONTACT ADDRESS: 450 RIVERCHASE PKWY
CITY/STATE/ZIP: BIRMINGHAM AL 35298

INS #2
INSURANCE CARRIER: 832004 BLUE CROSS PRO FEE
INSURED NAME: HUFFMAN,JAMES G
REL. TO INSURED: 1
SUBSCRIBER ID#: DIR418789424
GROUP NAME: SPECIAL OPEN ENROLLMENT PL
GROUP NUMBER: 91000
GROUP PHONE#: (800)760-6852
APPROVAL#
CONTACT
CONTACT ADDRESS: 450 RIVERCHASE PKWY
CITY/STATE/ZIP: BIRMINGHAM AL 35298

INS # 3
INSURANCE CARRIER: 380000 OTHER PPO
INSURED NAME: FFMAN,JAMES G
REL. TO INSURED:
SUBSCRIBER ID#: 418789424
GROUP NAME:
GROUP NUMBER:
GROUP PHONE#:
APPROVAL#:
CONTACT:
CONTACT ADDRESS:
CITY/STATE/ZIP:

DIAG CODE DIAGNOSIS: 786.50-CHEST PAIN NOS
ALLERGIES: CODEINE,TETRACYCLINE+
P:
PT. CL.:

ACCIDENT TYPE:
NATURE OF ACCIDENT:
ACCIDENT DATE:
TIME:

ARRIVAL MODE: OTHER AMBULANCE
REFERRING FACILITY:
CHURCH/DENOMINATION: CHR

ADMITTING PHYSICIAN: 509 FLEMMING,H FORREST
PRIMARY CARE PHUSICIAN: UNNINGHAM,SHANE

ATTENDING PHYSICIAN: 509 FLEMMING,H FORREST
REFERRING PHYSICIAN:

LOCATION:
E/R PHYSICIAN:

ADMISSION TYPE: URGENT

1/30/04

FS 100 PRINTED BY: b17606 DATE 10/5/2006

Last Printed: 01/29/2004 10:59:18
08/11/03 A01

2119 East South Boulevard
Montgomery, AL 36116
P.O. Box 250110
Montgomery, AL 36125-0110
(334) 280-1500

C. McGavock [illegible], MD, FACP, FACC
John L. Finkl[illegible] FACC
Robert P. Robi[illegible]ux, MD, FACC
Forrest Flemming, MD, FACC

[illegible]vid N. George, MD, FACC
[illegible]l B. Moore, MD, FACP, [illegible]CC
Wynne Crawford, MD, FACP, FACC
R. Eric Crum, MD, FACC

Michael F. S[illegible]D, FACC
Eliyya G. Ab[illegible]D, FACC
Beverly A. Stoudemire, MD, FACP, FACC

MEDICAL RECORD REQUEST:

- ☐ HP/Consult
- ☐ DC Summary
- ☐ CATH/PTCA
- ☐ OP Note
- ☐ Stress
- ☐ Echo
- ☐ _____

MONTGOMERY CARDIOVASCULAR ASSOCIATES, P.C.

Hospital 2/04

DISCHARGE INSTRUCTIONS

Patient's Name: James Huffman
Patient's Phone #: _____
MCA Acct. #: 89229
MCA M.D.: _____

Referring M.D.: ER / Fuentes
Hospital: BMC-So
Discharge Date: 2/20/04

Follow Up Appointment With Primary Physician On _____ At _____

Diagnosis: Chest Pain
CAD
Hyperlipidemia
PVD
Drug Abuse

Hospital Course/Procedures:

EKG + Enzymes Negative

New Allergies:

Discharge Medicines:

1. Plavix 75mg - daily until end of April
2. Lipitor 20mg - daily
3. Aspirin 81mg - daily
4. Nitrostat 0.4 mg - one under tongue every 5 minutes x needed for chest pain.
5. Lexapro 10mg - daily
6. Xanax and Percocet as directed
7. Nexium 40mg - daily

Diet: Low fat

Special Instructions:

Return to work: _____

May Drive: 2/20/04

Authenticated by
JOSE L. ESCOBAR, MD
On 2/26/04 11:41:20 AM

PLEASE BRING THIS SHEET & THE MEDICINES WITH YOU ON YOUR RETURN VISIT TO OUR OFFICE!

WHITE COPY: Patient YELLOW COPY: MCA PINK COPY: Referring M.D. GOLD COPY: Hospital (Please put in front of progress notes)

PRINTED BY: b17606 DATE 10/5/2006

JAC22

HISTPHYS86
BAPTIST HEALTH
2255
HUFFMAN, JAMES H
B0405000003
B000319167

PROBLEM LIST:
1. CHEST PAIN - NEGATIVE CARDIAC ENZYMES AND EKG - DURING POLICE ARREST
2. CORONARY ARTERY DISEASE, STATUS POST PTCA AND STENT OF LAD IN 2002, PTCA AND STENT OF CIRCUMFLEX CORONARY ARTERY IN 1/4 BY DR. FLEMMING, CHRONIC TOTAL OCCLUSION OF RCA WITH NORMAL LEFT VENTRICULAR FUNCTION.
3. DYSLIPIDEMIA.
4. SMOKER, CHRONIC OBSTRUCTIVE PULMONARY DISEASE.
5. PERIPHERAL VASCULAR DISEASE.
6. NONCOMPLIANCE WITH MEDICAL MANAGEMENT.

HISTORY: This is a 50 year old white male who, last night at approximately 8 p.m., while being arrested by the police due to what he states was an attempt to pay for his food at the deli shop with a check, was apparently arrested and, after that, developed some sternal chest discomfort with radiation to the left arm, and brought to the Emergency Room for further treatment. Negative cardiac enzymes and echocardiogram on admission to the Emergency Room, and pain relieved by Nitroglycerin. Presently pain-free.

PAST MEDICAL HISTORY:
1. Coronary artery disease, status post remote PTCA and stent of LAD and PTCA and stent of circumflex coronary artery in 1/2004 with chronic totally occluded RCA and preserved left ventricular function.
2. Dyslipidemia.
3. Peptic ulcer disease.
4. Lumbar disk disease.
5. Peripheral vascular disease.
6. Chronic obstructive pulmonary disease - asthma.
7. History of chronic anxiety.

PAST SURGICAL HISTORY: Laminectomy, PTCA and stenting.

ALLERGIES: CODEINE, TETRACYCLINE.

FAMILY HISTORY: Unknown.

SOCIAL HISTORY: Smoking, denies alcohol abuse, denies illicit drug abuse, although did not answer that frankly.

REVIEW OF SYSTEMS: Negative, otherwise.

PHYSICAL EXAMINATION: Blood pressure 105/57, heart rate 53 per minute, respiratory rate 18, temperature 97, saturation 100.

HEAD: Normocephalic, atraumatic.

NECK: No JVD or bruit.

CHEST: Clear to auscultation.

(CONTINUED)
PRINTED BY: b17606 DATE 10/5/2006

HEART: Regular rate and rhythm, S1, S2 without murmurs, rubs, gallops.

ABDOMEN: Benign.

EXTREMITIES: No clubbing, cyanosis, edema. Symmetrically +2 palpable pulses.

EKG: Sinus bradycardia; otherwise, negative.

CARDIAC ENZYMES: Troponin less than 0.04.

LABORATORY DATA: Pending.

PLAN: Admission to the floor, resume home medications as well as low molecular weight heparin, cardiac enzymes and cardiac catheterization by Dr. Flemming during the daytime. Will obtain drug screen, since the patient had slurred speech and was reluctant in answering if has been exposed to any illicit drugs. He consented for drug screen.

JOSE ESCOBAR, M.D.

JE/ / kb
D: 02/19/2004
T: 02/19/2004

D: 02/19/2004
T: 02/19/2004
kb

Authenticated by JOSE L. ESCOBAR, MD On 2/26/04 11:41:11 AM

BAPTIST MEDICAL CENTER
MONTGOMERY, ALABAMA 36111
RADIOLOGY REPORT

Patient Name: HUFFMAN,JAMES G
MR #: B000319167
Account #: 0405000003
Attending Physician: ESCOBAR,JOSE L

Date Performed: 02/19/04 0109
Patient's Room: CV-211-2
Patient Type:I/P

Exam
1010 DR-CHEST PA OR AP ONE VIEW
Ord Diag: ;CHEST PAIN

Check-in No.
1692442

HUFFMAN, JAMES

CHEST ONE VIEW:

Comparison 2/10/04. History of chest pain. No interval change.

Both lungs appear to be well expanded without an identifiable abnormality. Heart and cardiomediastinal structures are unremarkable. I do not identify an abnormality of the bony thorax. The pleural space and diaphragmatic shadows are unremarkable. Air spaces appear normal.

IMPRESSION:
1. NO ABNORMALITY IDENTIFIED.

/READ BY/ THOMAS S MOORE, M.D.
/Electronically Signed By/ THOMAS S MOORE, M.D.

BS

PRINTED BY: b17606 DATE 10/5/2006

HUFFMAN, JAMES

ID: 0000000003

19-Feb-2004 0:37:49

BAPTIST MEDICAL CENTER SOUTH

50years
Male Caucasian

Vent. rate 47 bpm
PR interval 162 ms
QRS duration 84 ms
QT/QTc 470/415 ms
P-R-T axes 64 72 65

Marked sinus bradycardia
Abnormal ECG

B04050000003 HUFFMAN,JAMES G
DOB: 10/29/53 Age:50Y MR #:319167
Admit Date/Time: 02/19/04 0100A
908 AUSTIN,JESSE W

Technician:

POOR ORIGINAL QUALITY

Referred by:

Unconfirmed

I aVR V1 V4
II aVL V2 V5
III aVF V3 V6
V5

150 Hz 25.0 mm/s 10.0 mm/mV

4 by 2.5s + 3 rhythm lds

MACVU 002E 12SL m v250

PRINTED IN U.S.A.

50years
Male Caucasian

Room: 211B
Loc: 9

Technician: 46

Vent. rate	60 bpm
PR interval	174 ms
QRS duration	82 ms
QT/QTc	434/434 ms
P-R-T axes	76 76 72

*** Age and gender specific ECG analysis ***
Normal sinus rhythm
Normal ECG

B0405000003 HUFFMAN,JAMES G
DOB: 10/29/53 Age:50Y MR #:319167
Admit Date/Time: 02/19/04 0247A
2255 ESCOBAR,JOSE L

Referred by: ESCOBAR

TEST TYPE:

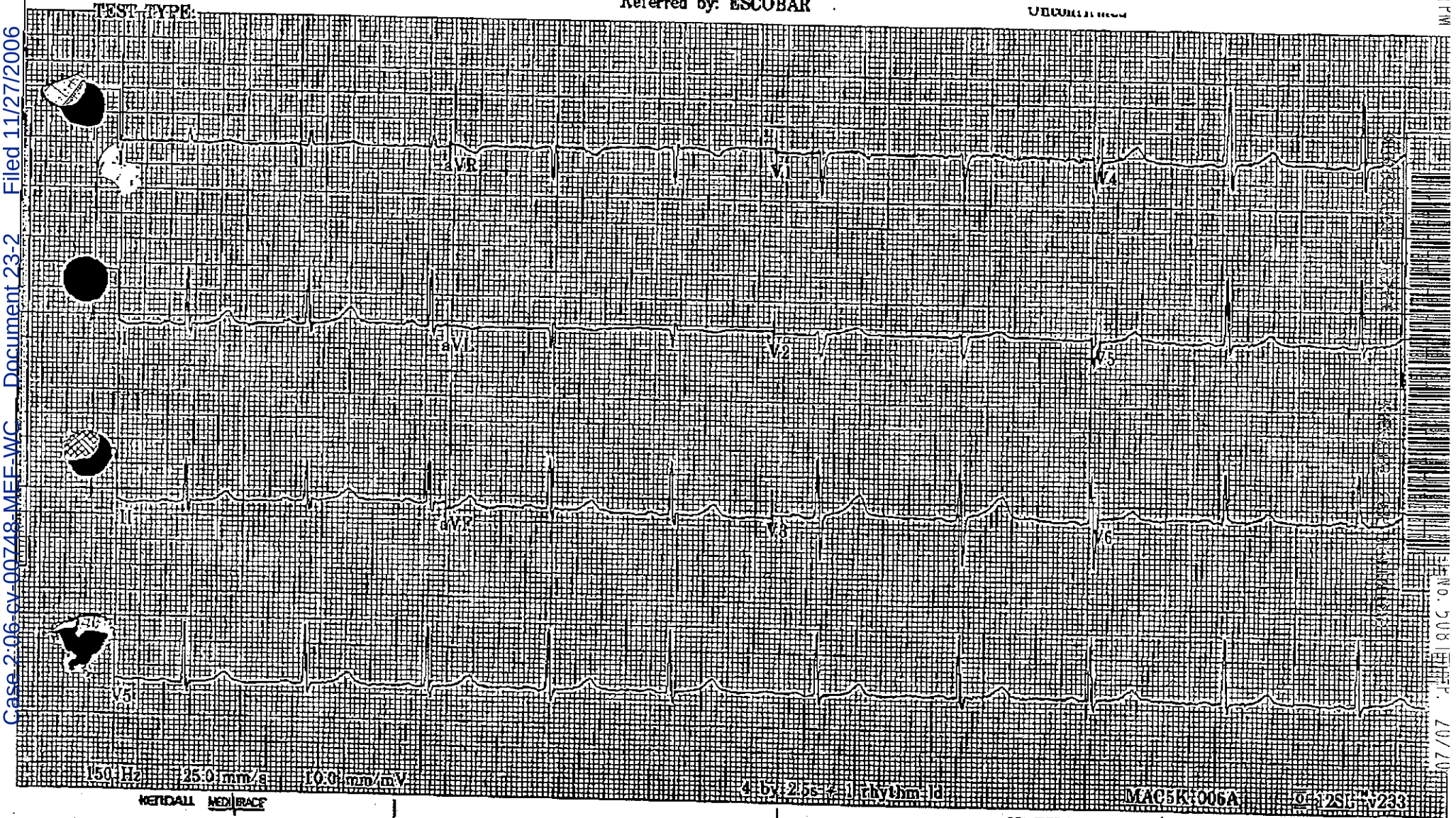

EXHIBIT B

Hospitalized Shelby Medical 4/06

SHELBY BAPTIST MEDICAL CENTER
ALABASTER, ALABAMA

DISCHARGE SUMMARY

NAME:	HUFFMAN, JAMES	**MR #:**	224062
DOB:	10/29/1953	**ADMISSION#:**	57129694
AGE/SEX	52 /M	**PT CLASS:** R	**ROOM:** 244
		CLINIC CODE:	2E
ADMITTED:	**04/23/2006 02:27**	**DISCHARGED:**	04/27/2006
ATT MD:		**FAMILY MD:**	

DIAGNOSES ON DISCHARGE:
1. Peripheral vascular disease with claudication.
2. Noncardiac chest pain.
3. Ongoing tobacco abuse.

HISTORY OF PRESENT ILLNESS: Patient is a 52-year-old white male presents with complaint of chest pain. Gives a textbook description, "elephant sitting on chest," jaw pain, left arm pain with associated nausea, diaphoresis, dyspnea. Patient, however, does not remember exertional pain but reports stress related. Patient has been incarcerated for forgery, which he denies. History of a stent at Baptist Montgomery, he cannot remember if 2004 or 2005.

RISK FACTORS FOR HEART DISEASE: Positive tobacco abuse, positive family history, positive hypertension. Negative diabetes mellitus. Positive hyperlipidemia.

MEDS ON ADMISSION: Plavix, Zocor, Xanax, Percocet, and Monopril.

ALLERGIES: CODEINE.

REVIEW OF SYSTEMS: HEENT: No headache. CARDIOVASCULAR: See history of present illness. PULMONARY: No cough, dyspnea. GI: No nausea, vomiting, diarrhea, melena, hematochezia, hematemesis. GU: No dysuria, frequency, or urgency. NEUROLOGIC: No seizure or syncopal disorder. VASCULAR: Positive for claudication of the right leg.

PHYSICAL EXAMINATION:
GENERAL: Reveals a well-developed, well-nourished, white male in no acute distress. HEENT: Normocephalic/atraumatic. Eyes: Extraocular movements are intact. Pupils equal, round, and reactive to light. Mouth: Tongue protrudes in the midline. NECK: Supple without bruits, lymphadenopathy, or thyromegaly. HEART: Regular rate and rhythm without murmurs, gallops, or clicks. LUNGS: Clear without rales, rhonchi, or wheezes. ABDOMEN: Soft, nontender. Bowel sounds are positive. No hepatosplenomegaly. NEUROLOGIC: No focal motor or sensory deficits. EXTREMITIES: Decreased pulses on the right leg.

HOSPITAL COURSE: Patient was admitted. Cardiology was consulted. Records were obtained from

SHELBY BAPTIST MEDICAL CENTER
ALABASTER, ALABAMA

DISCHARGE SUMMARY

Montgomery. After review, cardiologist recommended repeat cath. Cath was performed. It showed no change from previous cath done at Montgomery. Recommended medical therapy only. Patient was discharged to home. Will follow up with cardiologist regarding his coronary artery disease.

MICHAEL J TURNER, MD

TR: MT /SR D: 07/06/2006 07:41:00 T: 07/06/2006 09:25:43 JOB: 7108897 /1353668

ER visit Prattville 5/06

F0615000782 HUFFMAN,JAMES G
DOB: 10/29/53 Age:52Y MR #:191817
Admit Date/Time: 05/30/06 1929P
917 SULLIVAN,JOEL C

Baptist Health Nursing Chart Long Form

Page 1

Patient Name: _____ Arrival Time: _____
Family Doctor: Finklea Triage Time: 1940

Date: _____ Source: ☑ Patient ○ Other: _____ Birthdate: _____ Age: ____ ○ Pediatric (>29 days – 12 years)

Sex: ☑ M ○ F LMP: _____ Weight _____ kg (Actual) Height 5'11" Immunization status: _____ Last Tetanus: _____

Allergies: ○ NKA ○ Latex Allergy Reaction:

CHIEF COMPLAINT/Reason for Visit:

Chest Pain – 6 Pm

○ Return visit Same Day
○ Return visit within 72 hours
○ Workers Comp

MODE / METHOD OF ACCESS

Arrival Mode:	Entered by:	Patient Admitted from:	Treatment Prior to Arrival:		
☑ Automobile/Other	☑ Ambulatory	☑ Home	○ None	○ O2 Therapy	○ IV
○ Ambulance / Air	○ Wheelchair	○ Physician Office	○ Ice (EMS @ Jail)	○ Airway	○ Medications
○ Law enforcement	○ Stretcher	○ Nursing Home	○ Dressing(s)	○ Intubation	○ CPR
○ Auto Assist	○ Carried	○ Hospital	○ Splint(s)	○ Monitor	○ Glucose ____
	○ Other	○ Other	○ C-collar/Backboard	○ ACLS Protocol	○ Decon

VITAL SIGNS TAKEN: ○ *SITTING* ○ *LYING* ○ *STANDING*

Time	Temp	Route	Pulse	Resp	B/P	Pulse Ox	Time	Orthostatic Vital Signs (>0 / seated / standing)
1940	97.1	(O)	67	18	100/52	99%	Pulse	
							B/P	

PAIN SCALE

Numeric Scale 0=No Pain 10=Worst Pain Imaginable
☑ Pain Intensity Rate: 9 @ rest: ____
○ Face Scale: (Faces Scale/Wong & Baker) / FLACC

0 NO HURT · 2 HURTS LITTLE BIT · 4 HURTS LITTLE MORE · 6 HURTS EVEN MORE · 8 HURTS WHOLE LOT · 10 HURTS WORST

Onset of pain: Today
Location of pain: Chest
Quality: _____

Level of consciousness: ☑ A&O x3 ○ disoriented to: person / place / time / situation
○ dementia ○ decreased LOC ○ unconscious/comatose

Skin: ☑ Warm & Dry ○ Hot ○ Cool ○ Cold ○ Clammy ○ Diaphoretic ○ Pale

Safe in home: ☑ Yes ○ No Intervention:

ADVANCE DIRECTIVES ○ DNR ○ LIVING WILL ☑ NONE ○ Information Given

Past Medical History: ○ Denies ○ Unable to Assess

Exposure to: ○ HIV ○ Aids ○ SARS ○ STD Symptoms: _____

Vaccinations: ○ Pneumonia ○ Influenza ○ Information Provided

Tobacco ___ Pack/day Alcohol ___ drinks/day Substance Abuse _____ ○ Cessation Advised

Neuro: CVA TIA Migraines Seizures
EENT: Cataract Glaucoma HOH Blind
Cardiac: MI CHF CABG HTN Pacer Dysrhythmia
Pulmonary: Asthma Bronchitis COPD Pneumonia
GI: Ulcers GI Bleed Constipation Diverticulitis
GU: UTI Kidney Stone Prostate Dialysis AV Shunt
GYN: Pregnant now Ectopic
Ortho: Osteo Arthritis Back pain
Endo: Thyroid Diabetes
Cancer: _____
Psychiatric: Depression Alzheimer Autism Parkinson's Bi-polar Schizophrenia Prior Psych Admit Hostile on admission

Trauma Assessment ○ Yes ○ No
○ Assault ○ MVC Speed _____
○ Stab Impact: Rear / Front / T-Bone
○ GSW ○ Driver ○ Passenger
○ Fire ○ Front ○ Rear
○ Fall ____ ○ Airbag ○ Restrained
○ Motorcycle ○ Bicycle
Helmet ○ Yes ○ No
○ Other

CURRENT MEDICATION(S) **Meds Disposition:** ○ Patient ○ Family ○ Other

○ None	○ See Medication List (attached)		Nurse 1
○ Narcotics	Drug: Norvasc, Morphine, Asa, Plavix, Zocor, Xanax, Percocet	Count _____	Nurse 2

TRIAGE INTERVENTION(s): ○ Ice/Elevation ○ Dressing/Splint ○ Glucose ____ ○ EKG ○ C-Collar ○ Respiratory Precautions

Triage Category: ① ② ③ ④ ⑤

Triage disposition time ____ **TO** ○ ER Bed ____ ○ FT Bed ____
○ Waiting Room ○ Hallway Bed Report to:

Triage Nurse Signature: D Johnson **ID #** 13656.

ER160 PRINTED BY: b13736 DATE 10/9/2006

Form ER 16002 Rev. 01/27/06

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Admit Date/Time: 05/30/06 1929p
917 SULLIVAN,JOEL C

Airway and C-spine
- ✓ WNL
- O Abnormal

O Clear O Obstructed
O Intubated size _____ cm @ lip _____
O C-spine secured by ED staff

Breath Sounds
- ✓ WNL / Clear
- O Abnormal

	Rales	Rhonchi	Wheezes	Diminished	Absent
R	O	O	O	O	O
L	O	O	O	O	O

Respiratory
- ✓ WNL
- O Abnormal

O Labored O Apneic O Expiratory Grunting
O Rapid O Retractions O Cough - Productive
O Shallow O Stridor O Cough - Non-productive
O Nasal Flaring O Tracheal deviation O Sputum: color _____

O Home Oxygen ____ L/min

Cardiovascular
- O WNL
- O Abnormal

O Thready/weak ✓ Chest Pain/Tightness O Irregular
O Diaphoresis O Dizziness O Cyanosis
O Arrhythmia_____ O Edema O Pulses X 4

Notes: Monitor Rhythm
✓ See Strips O ICD

Neurological
- ✓ WNL
- O Not Assessed
- O Playful
- O Interactive with environment

O LOC O Combative O Lethargic
O Headache O Syncope O Tremors
O Disoriented O Seizures O Vertigo/Dizzy
O Speech difficulty / slurred O Confusion O Unresponsive
O Responds to Voice only O Responds to Pain only O Follows commands
O Change in mental status O Moves all extremities

Notes:
O Seizure precautions
O Neuro vital signs (see NN)
O Glasgow Coma Scale ____
O CVA Protocol (NIH Stroke Scale)

GI
- O WNL
- O Not Assessed

✓ N / V / D O Cramping O Constipation O Rigid Abd
vomiting x ___ O Pain O Distention O Tender Abd
O BS + - O Bleeding O Weight Loss / Gain O Last BM____

O *Nutritional risk* Yes No
O Dentures Upper Lower
O Meat Given

GU / GYN
- ✓ WNL
- O Not Assessed

O Pregnant O Pain O Freq/urgency O Amenorrhea
G___P___A____ O Distention O Incontinent O Dysmenorrhea
EDC _____ O Hematuria O Flank pain L R O Vaginal Bleeding
O FHTs _____ O Burning O Blood at Meatus O Discharge

Notes:
O Ostomy _____
O Foley size _____
Urine description:

Musculo-skeletal
- ✓ WNL
- O Not Assessed

O Pain O Unable to Assess Gait O Splinting
O Swelling O Unsteady gait O Weakness
O Deformity O Assist Device O History of falls

Notes: ***R L Handed***
Gait Device: Cane Walker
Crutches W/C Prosthesis

Integumentary
- ✓ Intact
- O Not Assessed

O Bruises O Wound O Pale O Cyanotic O Jaundice
O Rash O Laceration O Fistula : Location_____
O Abrasions O Lesions O Bruit + - O Thrill + -

Notes:
O Exposure to Chemicals
O Burns

EENT:
- ✓ WNL
- O Not Assessed

O Eye R L Both Pupil size R ___ mm L ___ mm Hearing Aid: R L B
O Ear R L Both O Drainage O Itching O Pain
O Nose O Throat O Dental O Congestion O Redness

O Visual Acuity
R 20/___ L 20/___ B 20/___
Glasses Contacts

Psychiatric:
- ✓ WNL
- O Not Assessed

O Memory changes O Delusions O Calm O Suicidal ideations
O Depression O Insomnia O Hostile O Homicidal ideations
O Anxiety O Hallucinations O Agitated ***Plan? Yes No***

Notes:
O Environment secured
O Restraints Present

Suspected: ✓ None
- O Child/Elder Abuse
- O Sexual Assault
- O Domestic Violence
- O Victim of Violent Crime

Referrals/Reporting:
- O Social Service
- O Behavioral Health
- O Police / Security
- O CPS / APS / DHHR
- O Animal Bite
- O Poison Control
- O SART / SANE

Communication Deficit:
- ✓ No deficit
- O Language barrier
- O Hearing Impaired
- O Uses Sign Language
- O Visually Impaired
- O Altered Mental Status
- O Translator _____

Dominant Language: _____

Developmental Milestones
O Achieved O Delayed

Barriers to learning: ✓ None
- O Physical limits _____
- O Emotional _____
- O Cultural _____
- O Religious/Spiritual _____
- O Suspected low literacy skills
- O Developmental disability

Safety measures addressed
- O Side rails Up
- ✓ ID Bracelet On
- O Risk of falls
- O Falls Bracelet

Support System:
- O Lives Alone
- ✓ Family/Significant Other
- O Minor w / Parent
- O Minor w/o Parent
- O Nursing Home
- O Assisted Living Home
- O Other

Marital Status: S M W D

Nurse Signature (Nurse completing assessment) ID # Time

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Baptist HEALTH Nursing Chart Long Form Page 3

Patient Name: _____

IV Push is medications given In < 16 minutes **MEDICATIONS** ***(Put medications in the same syringe on one line)***

Time	Route: IV Push	IM	SC	PO	Other	Medication	Dose	Site	Initials	Response to Medication: Time	Pain Scale Other	Initials
2014	O	O	O	O	●	NTG	1/150	SL	SW			
2014	O	O	O	●	O	ASA	325	PO	SW			
2014	O	O	O	●	O	MVD	60	PO	SW			
2034	●	O	O	O	O	Morphine	4mg	IV	SW			
2122	●	O	O	O	O	Morphine	4mg		hy			
2204	O	O	O	●	O	Plavix	75mg	PO	d	2200	feeling	d
2204	O	O	O	●	O	Xanax	1mg	PO	d		DCBD	d
	O	O	O	O	O							

O TD Adult O DT Pedi O Tetanus Toxoid O Rabies O Rabies IG O Other O VAR Completed

Thrombolytics: O Cardiac O Stroke O Vasopressors O Intraosseous Infusion O No response to med required

PARENTERAL THERAPY - IV FLUIDS O IV Pump O Warmed solution O Buritrol

Site	Per Hr IV	KVO	Lock	Start TIME	Stop TIME	Hydration	Medication	Solution/Additive Medication	Rate / Bolus	Repeat Med	Initials
1 Time 2015	Site R AC			2015	2205	●	O	NS	150/hr	O	SW
	Gauge 20G					O	O			O	
	Attempts x 1					O	O			O	
	Blood drawn					O	O			O	
2 Time	Per Hr IV O	KVO O	Lock O			O	O			O	
	Site _____					O	O			O	
	Gauge ____x__					O	O			O	
3 Time	Per Hr IV O	KVO O	Lock O			O	O			O	
	Site _____					O	O			O	
	Gauge ____x__					O	O			O	

INTAKE	Amount	OUTPUT	Amount
Oral		Urine	
IV		Gastric	
Other		Other	
TOTAL		TOTAL	

Response to IV therapy

● Tolerated well, no adverse reaction noted

Blood Transfusion

O Routine O Emergent

Total # of units _____

IV Site at disposition

Time: 2205 O Patent ● Discontinued

● No redness ● No swelling ● catheter intact

Vital Signs ● Continuous NIBP (strips attached)

Time	Temp	Pulse	Resp	B/P	Pulse Ox	Glucose Checks	Pain Scale

Titrated Medications O See flow sheet

Time	Med #1	Med #2	Med #3	Initials

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Form ER 16002 Rev. 01/27/06

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917 SULLIVAN,JOEL C

PROCEDURES / TREATMENT CARE

EYE
- O Eye Exam – ***NO FB found***
- O FB Eye Exam/Slit lamp
- O FB Eye Exam/No Slit lamp
- O Eye irrigation R L Both

Amount _____

NOSE/EAR
- O Nasal Cautery
- O Nasal packing-anterior
- O Nasal packing-posterior
- O Nasal packing-balloon
- O Ear irrigation (ear wax) R L

O Procedure "*Time Out*" by: _____

CARDIOLOGY
- O Cardiac monitor
- O EKG – by ED staff
- O Repeat EKG by ED staff
- O Pulse Ox-continuous
- O Central line O < 5yr O ≥ 5yr
- O External pacer
- O Temporary internal pacer
- O Cardioversion (electric)
- O Pericardiocentesis
- O Declot vascular device
- O PICC line O < 5yr O ≥ 5yr
- O Arterial Blood Gas
- O Blood / Needle exposure

GI / GU
- O Straight/quick cath for UA
- O Foley catheter Size_____
- O Bladder irrigation
- O Foley removed
- O Rectal exam O Anoscopy
- O Rectal disimpaction
- O Enema O Repeat x ___
- O NG w/ suction _____
- O NG w/ Lavage _____
- O G-tube replace O Reposition
- O Pelvic Exam
- O Sexual Assault Exam
- O Incontinence Care

RADIOLOGY
- O X-Ray preparation
- O CT US MRI IVP ___
- O IV contrast O Oral contrast
- O Monitor in radiology / CT

LAB
- O Venipuncture (ED Staff)
- O Lab Test (any)
- O Specimen collection(not blood)
- O Point of care test
- O Urine Dip O Rapid Strep
- O Central line blood draw
- O Hemocult + –
- O Genital cultures

SPECIAL PROCEDURES
- O Isolation (Medical)
- O Lumbar puncture
- O Epidural blood patch
- O Procedural sedation IV/IM
- O Paracentesis / Dx lavage
- O Hypothermia care
- O Hyperthermia care

BEHAVIORAL MANAGEMENT
- O Psychiatric evaluation
- O Restraints
- O Seclusion or 1:1 obs
- O Involuntary commitment
- O Psychiatric code called

PULMONARY
- O Airway: OralNasal O Oxygen Mask Cannula ___ Liters/min O End-tidal CO2 + –
- O Intubation Tube: _____
- O PTA O ED O Anesthesia
- O Rapid sequence induction
- O Ventilation assist Bi-Pap C-Pap
- O Cricothyroidotomy
- O Tracheostomy
- O Trach Care
- O Suction Oral/Nasal/Trach
- O Thoracentesis (Needle)
- O Chest tube insertion
- Tube size: _____ R / L O Bilateral
- O Nebulizer(s) X _____

- O CPR
- O **CODE** Time: _____
- Medical Pediatric Trauma
- O **Code Sheet Completed**
- Trauma team O 1 O 2 O 3

DISPOSITION / OUTCOME

PATIENT PROPERTY: O Sent home O Secured / hospital safe O Patient retains/accepts responsibility O Sent with patient
O Dentures O Glasses O Hearing device O Clothing O Cane O Crutches O Walker O Valuables O Other:

Discharged Time 2209
- O Nursing Home
- O AMA signed unsigned
- O LBMSE

Admitted Time _____ Room_____
- O Regular Room
- O Telemetry O ICU / CCU
- O Surgery O Cath Lab
- O Psychiatric O Observation

Transferred Time: ___
- O Hospital
- O Psychiatric

O **Extended Stay** (>4 hours)

O **Expired** Time: _____
- O Coroner called
- O Released to Funeral Home
- O Organ donation addressed

Notes:

TEACHING / DISCHARGE CARE

CORE MEASURES: O AMI O Pneumonia O Heart Failure O Stroke

Smoking cessation advised O <3 min O ≥3 min
- Discharge Instruction sheet provided
- Verbal understanding of discharge / RX
- O Meds dispensed by physician _____
- O Extended patient education

Instruction(s) given to:
- Patient
- O Parent / Family
- O Friend
- O Other

Discharge Mode:
- Ambulatory O Carried
- O Ambulance O Crutches
- O Wheelchair O Stretcher

Accompanied by:
- O Self /Parent
- O Spouse O Friend
- Police O Family
- O Other

O Work/School Excuse (see copy) O Workers Comp Papers Initiated (see copy) O **ED Boarder Time:**

TRIAGE OUT VITAL SIGNS

Time	Temp	Pulse	Resp	B/P	Pulse OX	Pain Scale	FHT
2209	56	12	134/77	98%			

Condition: improved O unchanged O _____

Triage Out Note: D/C inst, Rx reviewed c pt, Sheriffs Dept, stated understanding, stated feeling better,

Signature and Employee ID: Dallie Crisby 18364 Initials: dc

Admit Report called to: Time:

Signature and Employee ID: PRINTED BY: b13736 Initials: DATE 10/29/2006

Discharge Nurse: Dallie Crisby 18364 Initials: dc

%

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DOB: 10/29/53 Age:52Y MR #:191817
Admit Date/Time: 05/30/06 1929P
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Baptist Health
EMERGENCY PHYSICIAN RECORD
Chest Pain (5)

DATE: 5/30 TIME: ______ ROOM: 3 ___ EMS Arrival

HISTORIAN: (patient) spouse paramedics ______

__HX / __EXAM UNOBTAINABLE 2° TO: ______

HPI

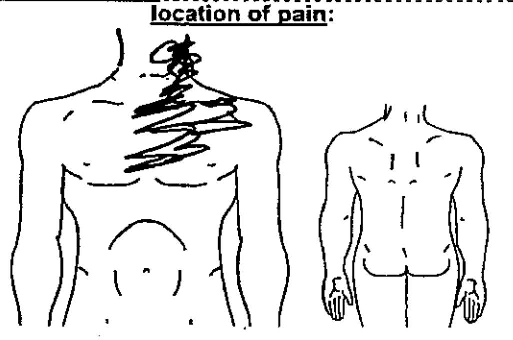
chief complaint: (chest pain) / discomfort

started: 6 pm
[illegible handwriting]

time course: (still present) better, gone now, lasted, resolved on arrival in ED
constant, "waxing & waning", intermittent episodes lasting ______, worse / persistent since ______

quality: (pressure, tightness), indigestion, burning, dull, aching, sharp, stabbing, "pain", "numbness", "like prior MI"

location of pain:



radiation: none, diagrammed above ______

associated symptoms: (nausea), vomiting, (shortness of breath), sweating

worsened by: change in position, (deep breaths / turning), exertion, nothing
??

relieved by: sitting up, rest, antacids, nothing

nitroglycerin 1 2 3 ___ patient's own supply, given by paramedics, relief- none / partial / complete / transient

Oxygen NRB ___ L

onset during: sleep, rest, light activity, mod. / heavy exertion, emotional upset, cannot recall
Bending Over

severity: maximum: (1-10) ______ mild (moderate) severe
when seen in ED: (1-10) gone, almost gone, mild, (moderate), severe
residual discomfort in arm (R/L)

Similar symptoms previously ______
[illegible handwriting]

Recently seen / treated by doctor
[illegible handwriting]

PAST HX
negative * = MI risk factors

- (*high blood pressure)
- *diabetes insulin / oral / diet
- (*high cholesterol)
- (*heart disease)
- heart attack (MI)
- angina / heart failure / (CAD)
- *DVT / PE / risk factors
- GERD
- other problems
- emphysema
- collapsed lung
- stroke
- peptic ulcer — documented? yes no
- gall stones
- thyroid disease

Surgeries / Procedures none non-contributory

- cardiac bypass
- (cardiac cath)
- (angioplasty) 2004
- thrombolytics
- pacemaker
- tonsillectomy
- cholecystectomy
- appendectomy
- hysterectomy
- defibrillator

Medications none (see nurses note)
NSAID acetaminophen BCP's
ASA time of last dose ______

Allergies NKDA
see nurses note ______
TCN

SOCIAL HX
recent ETOH *smoker drug abuse

FAMILY HX
DM (HTN) (CAD) (less than 55yo / greater than 55yo)
sudden death stroke diabetes

ROS
__HX / __EXAM UNOBTAINABLE 2° TO:

CHEST / CONST: fever, chills, cough, sputum, ankle swelling, calf / leg pain

NEURO: headache, blackouts

EYES / ENT: blurred vision, sore throat

GI / GU: abdominal pain, black / bloody stools, problems urinating

SKIN / LYMPH / MS: skin rash / swelling, joint pain

☑ all systems neg. except as marked

FEMALE REPRODUCTIVE: LNMP, vaginal discharge, abnormal bleeding

x ______ RN / PA / NP ______ MD

RN / PA / NP sign after recording history; physician initial after reviewing with patient and confirming or revising all elements.

☑ Nursing Assessment Reviewed ☑ Vitals Reviewed ☐ Bilateral BP

PHYSICAL EXAM

General Appearance
- no acute distress
- alert

EYES
- nml inspection

ENT
- ENT nml inspection
- pharynx nml

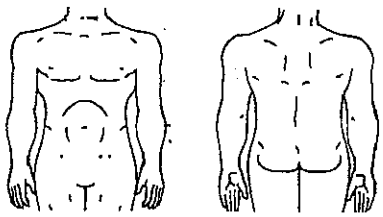
NECK
- nml inspection

RESPIRATORY
- no respl distress
- chest non-tender
- nml breath sounds

CVS
- regular rate, rhythm
- no murmur
- no gallop
- no friction rub
- normal pulses

__IV
__mild / moderate / severe distress
__anxious / lethargic
__scleral icterus / pale conjunctivae
__purulent nasal drainage
__pharyngeal erythema
__thyromegaly
__lymphadenopathy (R / L)
__see diagram
__respiratory distress
__manifests distinct pain on movement of (R / L) arm of trunk
__splinting / decr air mvmnt
__rales
__rhonchi
__wheezing
__irregularly irregular rhythm
__extrasystoles (occasional / frequent)
__tachycardia / bradycardia
__PMI displaced laterally
__JVD present
__murmur grade__/6 sys / dias cresc / cresc-decresc / decresc
__gallop (S3 / S4)
__friction rub
__decreased pulse(s) R carotd___ fem___ dors ped___ L carotd___ fem___ dors ped___

T = tenderness
G = guarding
R = rebound
ml = mild
mod = moderate
sv = severe
(e.g., Tsv = severe tenderness)



GASTROINTESTINAL
- non-tender
- no organomegaly

__tenderness
__guarding
__rebound
__abnml bowel sounds
__hepatomegaly / splenomegaly / mass

RECTAL
- non-tender
- heme neg stool

__black / bloody / heme pos. stool
__tenderness

SKIN
- color nml, no rash
- warm, dry

EXTREMITIES
- non-tender
- normal ROM
- no pedal edema
- no calf tenderness

__cyanosis / diaphoresis / pallor
__skin rash
__pedal edema
__calf tenderness
__clubbing

NEURO / PSYCH
- oriented x3
- mood / affect nml
- CN's nml as tested
- no motor / snsry deficit

__disoriented to: person / place / time
__depressed affect
__facial droop / EOM palsy / anisocoria
__weakness / sensory loss

EKG MONITOR STRIP ☑ NSR __Rate
__normal __abnormal

EKG ☑ NML ☐ Interp. by me ☐ Reviewed by me Rate
NSR nml intervals nml axis nml QRS nml ST/T

not / changed from:
Repeat EKG unchanged / [illegible]

LABS, EKG & XRAYS:

CBC	Chemistries		UA
normal except	*normal except*	Ca	*normal except*
WBC	BUN	Bilirubin	WBC
Hgb	Creat		RBC's
Hct	Gluc	Magnesium	bacteria
Platelets	Alk Phos	BNP	dip:
segs	ALT	D-Dimer	
bands	AST	CK	
lymphs	Na	CKMB	
monos	K	Troponin	
eos	Cl	PT	
	CO2	PTT	
		INR	

CXR ☐ Interp. by me ☐ Reviewed by me ☐ Discsd w/ radiologist
nml / NAD no infiltrates nml heart size nml mediastinum

not / changed from:
Pulse Ox ____% on *RA* / ___*L* / ___% *at (time)*
__normal __abnormal

treatment
Medications Given: time:
ASA ACE inhibitor Beta Blockers Thrombolytics Nitrates

Discharge Medications:

PROGRESS:

Re-evaluation time 213k unchanged improved re-examined
Re-evaluation time 22w unchanged improved re-examined
*Re-evaluation time*____ unchanged improved re-examined

CP - acute mvt ↑ Benign. stable
22w - lungs • hilli ⊂ gmd

TREATMENT: • angina protocol NTG, MS, MVR
• unstable angina protocol
• acute MI protocol or acute coronary syndrome protocol
MEDICAL DECISION:
__Rx given

__Follow up with

Relinquished care to Dr. Time:

__Discussed with Dr.
will see patient in: office / ED / hospital
__Counseled patient / family regarding:
lab results diagnosis need for follow-up
__Admit orders written

__CRIT CARE- *30-74 min* *75-104 min* ____ *min*
__Prior records ordered
__Additional history from:
family caretaker paramedics

CLINICAL IMPRESSION:

Chest Pain - *acute precordial*	Acute MI
Chest Wall Pain - *acute*	Unstable Angina
Dyspnea - *acute*	Pericarditis - *acute*
Costochondritis - *acute*	Acute Aortic Dissection
Myofascial Strain - *acute*	Pulmonary Embolism
Viral Syndrome - *acute*	Acute Pulmonary Edema / CHF
Bronchitis - *acute*	Atrial Fibrillation - *rapid vent. response*
Viral Pleuritis (Pleurisy)	*controlled uncontrolled new-onset chronic*
Abnormal EKG	Pneumonia
GERD	Pneumothorax

DISPOSITION- ☐ home ☐ admitted ☐ transferred
CONDITION- ☐ unchanged ☐ improved ☑ stable

x_____MD / DO x_____MD /DO
Resident *Attending*

☐ *Hx review, Patient interviewed, Medical Decision Making, and Examined by Physician.*

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F0615000782 HUFFMAN,JAMES G
DOB: 10/29/53 Age:52Y MR #:191817
Admit Date/Time: 05/30/06 1929P
917 SULLIVAN,JOEL C

Baptist HEALTH

ER PRESCRIPTION & DISCHARGE INSTRUCTIONS

DISCHARGE INSTRUCTIONS - PATIENT COPY

Weight	Phone	Allergies	Location
		Tetracycline	SOUTH

MEDICINES PRESCRIBED | If non, check this box: ☐ | **VOID IF NOT PRINTED WITH CRANBERRY BACKGROUND.**

Name/Strength;	Number	Schedule / Duration	No Refills	Refills
1.			☑	
2.			☐	
3.			☐	
4.			☐	
5.			☐	

INSTRUCTIONS SHEET(S) GIVEN

- ☐ Asthma
- ☐ Back Pain
- ☐ Cast/ Splint Care
- ☐ Crutches
- ☐ Fever
- ☐ Fracture
- ☐ Head Injury
- ☐ Otitis Media
- ☐ Sprains / Bruises
- ☑ ST
- ☐ Threatened Ab
- ☐ Vomiting / Diarrhea
- ☐ Wound Care
- ☐ Other(s)

Return for signs of infection
Increased Redness
Increased Swelling
Increased Drainage
Increased Heat

Additional Instructions:

Referred to:
☐ Dr. _____
Phone: _____
☐ Call on next business day for follow-up appointment in _____days / weeks ☐ Next available

☐ Return to Emergency Dept in _____hours / days for recheck.
☑ If no improvement or your condition worsens, call your private physician or return to the Emergency Department for a recheck.
☑ Learning needs assessed ☐ Instructions Modified_____
☑ Education provided on new Medication Plavix

I understand that the treatment I have received was rendered on an emergency basis and is not meant to replace complete care from a primary care provider or clinic. Furthermore, I many have been released before all of my medical problems were apparent, diagnosed, and/or treated. If my condition worsens, I have been instructed to call my primary care provider or return to this facility or the nearest emergency center. I understand that I should NOT drive or perform hazardous tasks if my medication or treatment causes drowsiness. I have read and understand the above, received a copy of this form and applicable instruction sheets, and I will arrange for follow-up care. If diagnostic tests indicate a need for modification in therapy, you will be notified at the phone number you provided.

X James G Huffman ☐ Patient ☐ Relative ☐ Other _____ Time Released: > 2209 Hrs

INSTRUCTED BY: Dawn Christy PHYSICIAN:

WORK/SCHOOL STATEMENT from the Emergency Department

PATIENT DATE

- ☐ Patient was seen by Dr._____
- ☐ No athletics / physical education: _____days
- ☐ May return to work/school without restrictions
- ☐ Will require time off work / school. Estimated time: _____days*
- ☐ Must be reevaluated by family / occupational physician before returning to school / work.
- ☐ May return to restricted duties for _____days*
  Restrictions:_____
- ☐ _____was here with relative/child.
- ☐ Other_____

Time off from school or work longer than three days should be approved by a Personal or Company/Occupational Medicine Physician, unless otherwise stated.

ER 160 PRINTED BY: b13736 DATE 10/9/2006

FORM # ER 16006 REV. 03/07/06

%

F0615000782 HUFFMAN,JAMES G
DOB: 10/29/53 Age:52Y MR #:191817
Admit Date/Time: 05/30/06 1929P
917 SULLIVAN,JOEL C
Patient Information

Baptist Health

AERAS PHYSICIAN ORDER SHEET

Date/Time	TEST	SYMPTOMS		
PROCEDURE SET-UPS				
	❑ Visual Acuity			
	❑ Eye Box	❑ Morgan Lens ❑ Tetracaine	❑ Corneal Burr ❑ Tonopen	❑ Dacriose ❑ Woods Lamp
	❑ Nose Tray	❑ Head Light		
	❑ Dental Box			
	❑ Ortho Box			
	❑ Pelvic Exam			
	❑ Lumbar Puncture			
	❑ NG-Tube			
	❑ Splint			
	❑ Crutch Walking			
	❑ Suture Set-Up			
BEHAVIORAL HEALTH				
	❑ Psychiatric Evaluation/Screening			
	❑ Restraints	See Restraint Order Sheet		❑ 1:1 Seclusion
IV FLUIDS				
	❑ IV Site _ x1 _ x2			
	❑ IV Bolus	❑ _____ X500ml	❑ _____ 1 Liter	❑ _____ 2 Liters
	❑ IV Fluids	_____ at _____ ml/hr	_____ at _____ ml/hr	_____ at _____ ml/hr
	❑ IV Critical Drips	Cardizem	Nitroglycerin	Dopamine
		Nipride	Integrillin	Other

TIME	MEDICATIONS	TIME	MEDICATIONS
	NS @ 100		Morphine IV
	NTG 1/150 SL		
	ASA 325		Xanax 1mg PO
	MVI 60 cc IV		Plavix 75 PO
	Morphine IV		❑ See additional medication order form.

TIME	CONSULTS			
	❑ Primary Physician Time Notified / Time Responded	❑ On-Call Specialist Time Notified / Time Responded	❑ GMS/FMS/Hospitalist Time Notified / Time Responded	❑ Other Time Notified / Time Responded

DISPOSITION				
TIME	DISCHARGE	ADMISSION	TRANSFER	EXPIRED
	❑ Home	❑ Regular Room #____	❑ Hospital	❑ Coroner Called
	❑ AMA signed unsigned	❑ Telemetry Room #____	❑ Psychiatric/Meadhaven	❑ Death Certificate Signed
	❑ Elopement	❑ Observation Room #___	❑ Other	
	❑ LBMSE	❑ Surgery		
	❑ Work/School Excuse Provided x's ___ Days		❑ Workers Comp Papers Initiated	

PHYSICIAN SIGNATURE:	EXTENDER SIGNATURE:
Certified Medical Emergency ❑ Yes ❑ No	Dictation #

ER 160

PRINTED BY: b13736 DATE 10/9/2006

Pratt City Baptist Hospital LABORATORY
Name: HUFFMAN, JAMES G DOB: 10/29/1953
MR: F000191817 Acct: F0615000782
AdmPhys: Sullivan, Joel C., MD
Admit date: 05/30/2006 Discharge date: 05/30/2006

CHEMISTRY

COLLECTION DATE: 5/30/06
COLLECTION TIME: 8:19:00 PM

		REF RANGE	UNITS
Gluc	137 H	[60-120]	mg/dL
BUN	18	[7-20]	mg/dL
Creat	1.0	[0.6-1.4]	mg/dL
Sodium	136	[135-145]	mmol
Potassium	4.2	[3.5-5.0]	mmol
Chloride	102	[97-112]	mmol
CO2	28	[22-32]	mmol
Calcium	8.8	[8.5-10.5]	mg/dL
Total Protein	6.9	[6.4-8.2]	gm/dl
Albumin	3.8	[2.8-5.0]	gm/dl
Alk Phos	88	[50-136]	u/l
ALT	32	[0-55]	u/l
AST	13	[8-42]	u/l
Bili Total	0.1	[0.0-1.0]	mg/dL
Magnesium	2.0	[1.6-2.4]	mg/dL
proBNP i	57	[0-299]	pg/mL

05/30/2006 08:19:00 PM proBNP:
<300 mg/dL excludes CHF

Cardiac Enzymes

COLLECTION DATE: 5/30/06
COLLECTION TIME: 8:19:00 PM

		REF RANGE	UNITS
Troponin-I	<0.04	[<=0.60]	ng/mL

%%END

Pratt Cable Regional Hospital LABORATORY
Name: HUFFMAN, JAMES G DOB: 10/29/1953
MR: F000191817 Acct: F0615000782
AdmPhys: Sullivan, Joel C., MD
Admit date: 05/30/2006 Discharge date: 05/30/2006

COAGULATION

COLLECTION DATE: 5/30/06
COLLECTION TIME 8:19:00 PM

		REF RANGE	UNITS
PT	11.3	[10.2-12.9]	Sec
INR	0.95	[0.90-1.19]	
PTT	26	[21-33]	Sec
D-Dimer Advanced i	0.43	[0.40-2.50]	mg/L

05/30/2006 08:19:00 PM D-Dimer Advanced:
D-Dimer with a result of < 1.0 mg/L
can be used to RULE OUT
the diagnosis of DVT and PE.

%%END

Prattville Baptist Hospital LABORATORY
Name: HUFFMAN, JAMES G DOB: 10/29/1953
MR: F000191817 Acct: F0615000782
AdmPhys: Sullivan, Joel C., MD
Admit date: 05/30/2006 Discharge date: 05/30/2006

HEMATOLOGY

Routine Hematology

COLLECTION DATE: 5/30/06
COLLECTION TIME: 8:19:00 PM

		REF RANGE	UNITS
WBC	15.4 H	[4.1-10.3]	X10-3/uL
RBC	4.00 L	[4.69-6.13]	X 10-6/uL
Hemoglobin	13.0	[13.0-17.5]	gm/dl
Hematocrit	39.4 L	[40.0-51.0]	%
MCV	99	[81-100]	FL
MCH	33 H	[27-31]	pg
MCHC	33	[32-35]	gm/dl
Platelet Count	345	[140-400]	X10-3/uL
RDW	14.8 H	[11.5-14.5]	%

Automated Differential

COLLECTION DATE: 5/30/06
COLLECTION TIME: 8:19:00 PM

		REF RANGE	UNITS
Neutro Auto	61	[40-75]	%
Lymph Auto	24	[20-53]	%
Mono Auto	10	[0-12]	%
Eos Auto	4	[0-8]	%
Basophil Auto	1	[0-2]	%
Neutro Abs	9.5 H	[1.4-6.5]	#
Lymph Abs	3.7	[1.0-4.8]	#
Mono Abs	1.5 H	[0.1-0.6]	#
Eos Abs	0.7	[0.0-0.7]	#
Basophil Abs	0.1	[0.0-0.2]	#
Scan	Auto Diff Verified		

%%END

PRINTED BY: b13736 DATE 10/9/2006

Prattville Baptist Hospital RADIOLOGY
Name: HUFFMAN, JAMES G DOB: 10/29/1953
MR: F000191817 Acct: F0615000782
AdmPhys: Sullivan, Joel C., MD
Admit date: 5/30/2006 Discharge date: 5/30/2006

RADIOLOGY

Procedure Name:	Accession Number:	Procedure Date / Time:	Ordering Physician:
DX Chest Portable	DX-06-0061208	5/30/2006 08:06:00 PM	Sullivan, Joel C., MD

Reason For Exam:
chest pain

FINDINGS
HUFFMAN, JAMES G

PORTABLE CHEST:

Both lungs appear to be well expanded without an identifiable abnormality. Heart and cardiomediastinal structures are unremarkable. I do not identify an abnormality of the bony thorax. The pleural space and diaphragmatic shadows are unremarkable. Air spaces appear normal.

IMPRESSION:
1. NO ABNORMALITY IDENTIFIED.

ELECTRONICALLY SIGNED BY: Bailey, Joseph M, MD

TECHNOLOGIST: JLS
TRANSCRIBED DATE AND TIME: 05/31/2006 09:35
TRANSCRIPTIONIST: tlb

%%END

PRINTED BY: b13736 DATE 10/9/2006

0615000782 05/30/2006 09:23:04 PM HUFFMAN, JAMES
52 years Male

Prattville Baptist Hospital

Room:
Oper: DH

Rate	59
PR	171
QRSD	86
QT	429
QTc	425
--AXIS--	
P	51
QRS	38
T	64

. Normal sinus rhythm, rate 59

% Bed 3

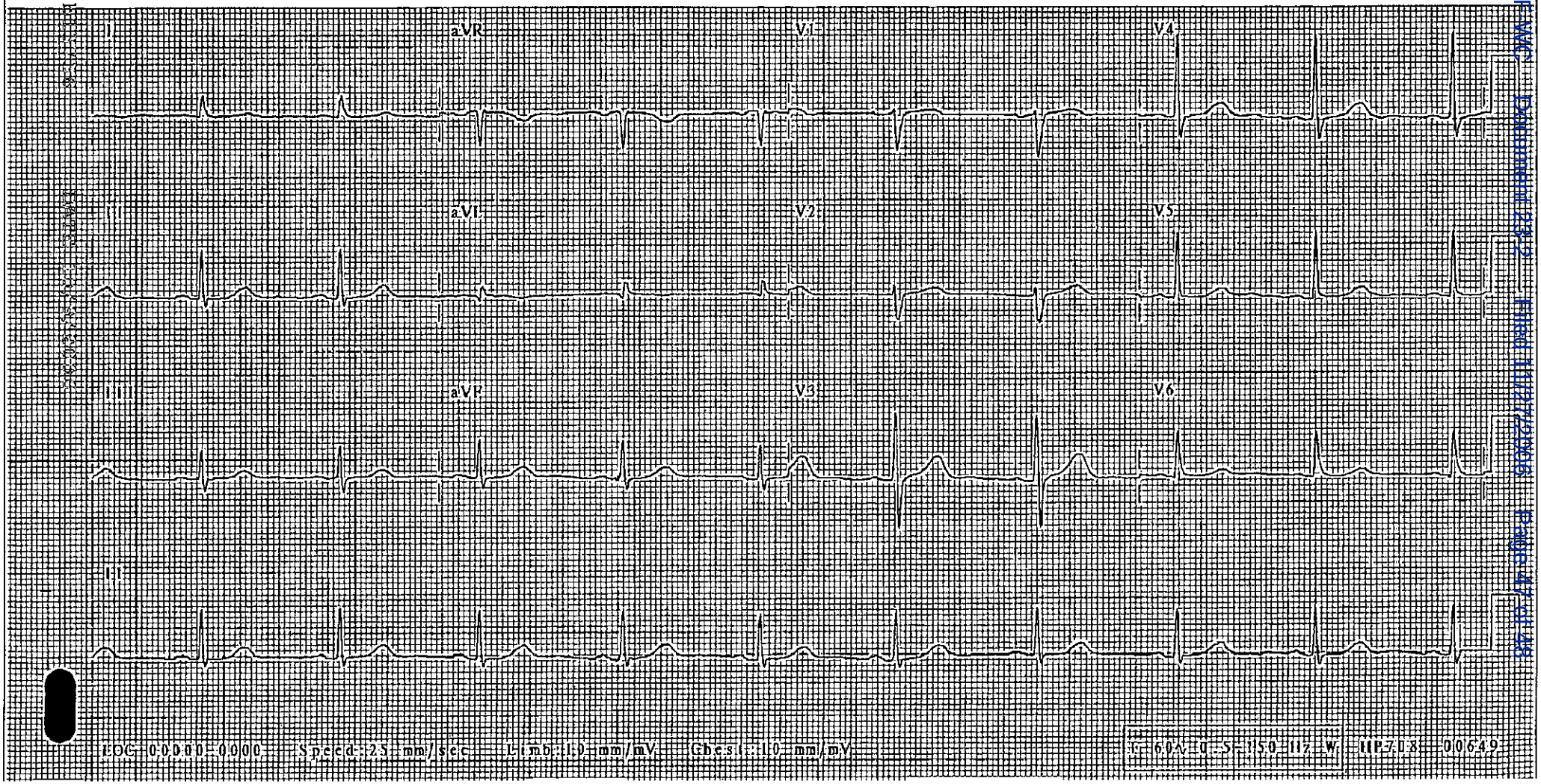
F0615000782 HUFFMAN,JAMES G
DOB: 10/29/53 Age:52Y MR#:191817
Admit Date/Time: 05/30/06 1929P
917 SULLIVAN,JOEL C

Requested by:

- NORMAL ECG -

PRELIMINARY-MD MUST REVIEW

PRINTED BY:



0615000782 05/30/2006 07:59:34 PM HUFFMAN,JAMES
52 years Male

Prattville Baptist Hospital

Room:
Oper: DH

Rate	63
PR	169
QRSD	85
QT	400
QTc	409
--AXIS--	
P	62
QRS	54
T	72

. Normal sinus rhythm, rate 63

%

F0615000782 HUFFMAN,JAMES G
DOB: 10/29/53 Age:52Y MR #:191817
Admit Date/Time: 05/30/06 1929P
917 SULLIVAN,JOEL C

Requested by:

- NORMAL ECG -

PRELIMINARY-MD MUST REVIEW

PRINTED BY: